Form Instructions For HHAs' Completion of the Home Health Advance Beneficiary Notice (CMS-R-296)

Instructions for Completion of the HHABN (CMS-R-296)

A. General Rules--

1. Prepare and deliver to the patient (Medicare beneficiary), or his/her authorized representative, an HHABN when you expect Medicare probably will not pay for, or will not continue to pay for, services on the basis of one of the following statutory exclusions:
   a. The patient does not need intermittent skilled nursing care - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Social Security Act.
   b. The patient is not confined to the home - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Act.
   c. The service may be denied as "not reasonable and necessary" ("medical necessity") - §1862(a)(1) of the Act.
   d. The service may be denied as "custodial care" - §1862(a)(9) of the Act.

2. You (the home health agency) must ensure that the readability of the HHABN facilitates patient understanding. No insertion into the blanks, boxes, and customizable area (the header) of the HHABN, if typed or printed, should use italics nor any font that is difficult to read. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. If insertions are handwritten, they must be legible. In all cases, both the originals and copies of HHABNs must be legible and high-contrast. When Spanish language HHABNs are used, you should make insertions on the form in Spanish to the best of your ability; where that is impossible, you need to take other steps as necessary to ensure that the patient understands the notice.

B. Header of HHABN--

1. The header of the HHABN, above the title "HOME HEALTH ADVANCE BENEFICIARY NOTICE," is a customizable area of the CMS-R-296, which you may customize for your use, consistent with the requirements of paragraphs A.2 and B.2.

2. The HHABN's header must include your identifying information, including your name, address and telephone number. You may elect to include your logo (if any). The following required elements must be included in the header. Within these general rules, you may customize a notice header.
   a. Date--The date on which you gave the notice personally to the patient or authorized representative. Where personal delivery is not possible, include both the date you notified the patient by telephone and the date you mailed the notice.
   b. Patient's Name--The name of the patient (do not substitute the name of an authorized representative).

c. Medicare # (HICN)--The patient's health insurance claim number. An HHABN could be invalidated for the lack of a Medicare HICN if the patient-recipient of the HHABN alleges that it was signed by someone else of the same name and the RHHI cannot resolve the matter with certainty.
d. Physician--The attending physician's name and telephone number.

C. Body of HHABN--

1. In the paragraph beginning "We, ___, your home health agency, expect …", in the first line provided, enter your name (the name of the home health agency).

2. In the same paragraph, in "… expect Medicare probably will not pay for:_____", the second line provided, specify the home health care services, for which you expect that Medicare will not pay, in sufficient detail so that the patient can understand precisely what services may not be furnished and include any pertinent dates, e.g., "… furnished on or after [date]." It is essential that the effective date(s) be included in the specification of services.

3. In the same paragraph, in the third line provided, "because: ____", give the specific reason why you expect Medicare to deny payment. The reason cited must be in understandable lay language and must be sufficiently specific to allow the patient to understand the basis for your expectation that Medicare will deny payment, and, if necessary, to gather evidence to the contrary from a physician and/or others in support of the coverage of such services (e.g., "our clinical assessment of your condition indicates that you can benefit from physical therapy services twice weekly, but that additional physical therapy services each week would not be beneficial"). Avoid using abbreviations.

4. On the line, "We estimate … will cost about $_____", you are required to enter the estimated cost of the services. You are not required to express the cost estimate in any specific format. You must respond timely, accurately, and completely to a patient, or authorized representative, who requests information about the extent of the patient's personal financial liability for home health care for which you expect that Medicare may not, or may no longer, pay. You must respond to the patient's request for a cost estimate in terms which the patient can understand.

5. "You can telephone us at:___" Lines--Enter your office telephone number on the first line. Enter your TTY/TDD telephone number (or directions for using your other telecommunication system for individuals with impaired speech or hearing) on the second line.

6. "Your other insurance is:___" Line--If the patient has any insurance other than Medicare, enter that insurance in this line. In the case of a Medicare-Medicaid dually-eligible beneficiary, refer to that patient's Medicaid coverage by the name for that coverage used in the patient's State, e.g., in California, enter "Medi-Cal."

D. Option Boxes--

1. You must enter the RHHI's telephone numbers in Option A before presenting the HHABN to the patient. Enter your local RHHI's office telephone number on the first line and your local RHHI's TTY/TDD telephone number (or directions for using your other telecommunication system for individuals with impaired speech or hearing) on the second line.

2. Do NOT pre-select any option.

3. The patient must select one option.

a. If the patient selects Option A, the patient may receive the subject home care services, for which a demand bill must be submitted to Medicare for an official determination.

b. If the patient selects either box in Option B, the patient may receive the subject services but a claim for those services is not to be sent to Medicare. If the patient selects box B.1 ("Please submit a claim to my other insurance, but not to Medicare"), send a claim to the state Medicaid program and/or to any other insurer, as may be appropriate. If the patient selects box B.2 ("Do not submit a claim either to Medicare or to my other insurance"), do not send a claim to Medicare, nor to the state Medicaid program, nor to any other insurer, because the patient has elected to keep his/her health information confidential and does not want the information disclosed to any third party; in this case, the patient is on a private-pay basis.

c. If the patient selects Option C, the patient has elected not to receive the subject home health services.

E. Signature Requirements for HHABN.--

1. On the "Date" line, the patient, or person acting on his or her behalf, enters the date on which he or she signed the HHABN.

2. On the "Signature of patient…" line, the patient, or person acting on his or her behalf, must sign his or her name.

a. The patient may sign an HHABN. In the case of a patient who is incapable or incompetent, his or her "authorized representative," as defined for HHABN purposes, may sign an HHABN. The regulations on signature requirements for claims purposes at 42 CFR 424.36 do not apply to HHABNs.

b. If the patient's (or the authorized representative's) signature is absent from an HHABN, in case of a dispute as to the patient's (or authorized representative's) receipt of the HHABN, the RHHI will give credence to the patient's (or authorized representative's) allegations regarding the HHABN. However, if the beneficiary (or the authorized representative) refuses to sign the HHABN but demands the services, the guidance in subparagraph 2.e., below, should be followed.

c. You must obtain the signed (containing the signature of the patient or authorized representative acting on the patient's behalf,) and dated HHABN with Option A, B, or C checked as to the action the patient wants to take, from the patient, either in person or, where this is not possible, via return mail from the patient or authorized representative acting on the patient's behalf as soon as possible after the HHABN has been signed and dated. The patient retains the patient's copy of the signed and dated HHABN and returns the original to you. Annotate the original of the HHABN with the date of your receipt from the patient. Return a copy of the HHABN, including the date of your receipt, within 30 calendar days to the patient for his or her records. You retain the original HHABN. These copies will be relevant in the case of any future appeal. Where the HHABN is signed and dated in the presence of your staff or employee, the annotation of the date of your receipt of the signed and dated HHABN may be made directly on both the original and patient's copy, and a second patient copy of the annotated original is not required.

d. If a patient who chose "Option C. No." later requests that a claim be submitted to Medicare, consistent with option A, annotate your copy of the HHABN with the date of your receipt of the new request, and return a copy of the annotated HHABN within 30 calendar days to the patient for his or her records.

e. If the patient, or the authorized representative acting on his or her behalf, refuses to sign the HHABN and/or refuses to choose any option, annotate your copy of the HHABN, indicating the circumstances and persons involved. If this occurs, you must decide whether or not to furnish services to the patient in light of the fact that the patient has not agreed to be fully and personally responsible for payment for services that are not covered by Medicare. If, under these circumstances (i.e., the patient refuses to pay but demands the services), you decide to provide the services, you should have a second person witness the provision of the HHABN and the patient's refusal to sign. They should both sign an annotation on the HHABN attesting to having witnessed said provision and refusal. Where there is only one person on site, the second witness may be contacted by telephone to witness the patient's refusal to sign the HHABN by telephone and may sign the HHABN annotation at a later time. The unused patient signature line on the HHABN form may be used for such an annotation; writing in the margins of the form is also permissible.

F. Burden Notice-- According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0781. The time required to complete this information collection is estimated to average 6 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.